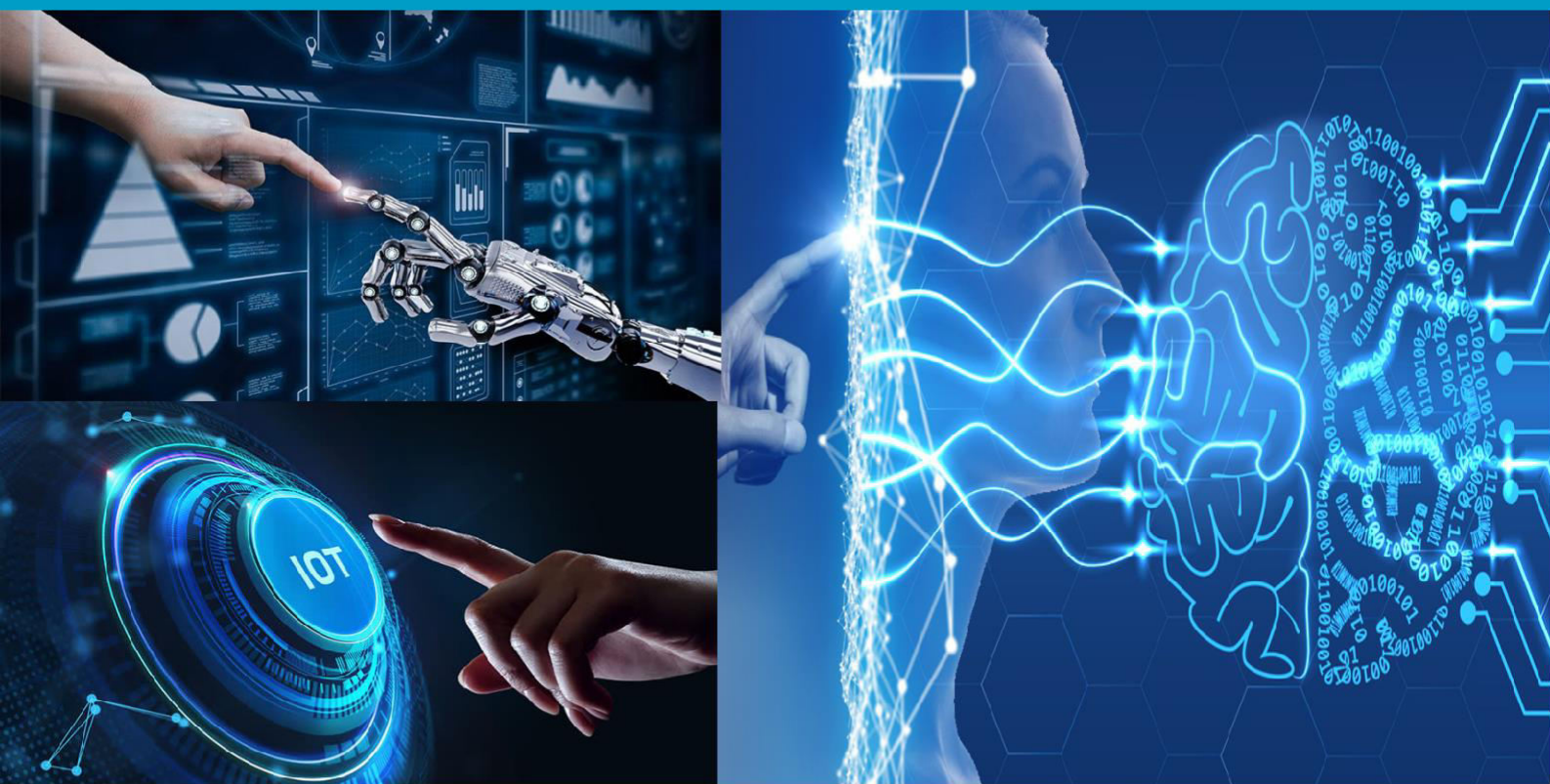




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Service Quality Dimensions: A Context of Life Insurance

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ABSTRACT: Service quality (SQ), in its contemporary conceptualisation, is a comparison of perceived expectations (E) of a service with perceived performance (P), giving rise to the equation $SQ=P-E$.^[1] This conceptualisation of service quality has its origins in the expectancy-disconfirmation paradigm.^[2]

A business with high service quality will meet or exceed customer expectations whilst remaining economically competitive.^[3] Evidence from empirical studies suggests that improved service quality increases profitability and long term economic competitiveness. Improvements to service quality may be achieved by improving operational processes; identifying problems quickly and systematically; establishing valid and reliable service performance measures and measuring customer satisfaction and other performance outcomes.^[4]

Life insurance (or life assurance, especially in the Commonwealth of Nations) is a contract between an insurance policy holder and an insurer or assurer, where the insurer promises to pay a designated beneficiary a sum of money upon the death of an insured person (often the policyholder). Depending on the contract, other events such as terminal illness or critical illness can also trigger payment. The policyholder typically pays a premium, either regularly or as one lump sum. The benefits may include other expenses, such as funeral expenses.

Life policies are legal contracts and the terms of each contract describe the limitations of the insured events. Often, specific exclusions written into the contract limit the liability of the insurer; common examples include claims relating to suicide, fraud, war, riot, and civil commotion. Difficulties may arise where an event is not clearly defined, for example, the insured knowingly incurred a risk by consenting to an experimental medical procedure or by taking medication resulting in injury or death.

Modern life insurance bears some similarity to the asset-management industry and life insurers have diversified their product offerings into retirement products such as annuities.^[2]

Life-based contracts tend to fall into two major categories:

- Protection policies: designed to provide a benefit, typically a lump-sum payment, in the event of a specified occurrence. A common form of a protection-policy design is term insurance.
- Investment policies: the main objective of these policies is to facilitate the growth of capital by regular or single premiums. Common forms (in the United States) are whole life, universal life, and variable life policies.

KEYWORDS: service quality, life insurance, legal contracts, policy, customer satisfaction, competitive

I. INTRODUCTION

An early form of life insurance dates to Ancient Rome; "burial clubs"^[3] covered the cost of members' funeral expenses and assisted survivors financially. In 1816, an archeological excavation in Minya, Egypt (under an Eyalet of the Ottoman Empire) produced a Nerva–Antonine dynasty-era tablet from the ruins of the Temple of Antinous in Antinoöpolis, Aegyptus that prescribed the rules and membership dues of a burial society collegium established in Lanuvium, Italia in approximately 133 AD during the reign of Hadrian (117–138) of the Roman Empire.^[4] In 1851, future U.S. Supreme Court Associate Justice Joseph P. Bradley (1870–1892), once employed as an actuary for the Mutual Benefit Life Insurance Company, submitted an article to the Journal of the Institute of Actuaries detailing an historical account of a Severan dynasty-era life table compiled by the Roman jurist Ulpian in approximately 220 AD during the reign of Elagabalus (218–222) that was included in the Digesta seu Pandectae (533) codification ordered by Justinian I (527–565) of the Eastern Roman Empire.^[5]

The earliest known life insurance policy was made in Royal Exchange, London on 18 June 1583. A Richard Martin insured a William Gybbons, paying thirteen merchants 30 pounds for 400 if the insured dies within one year.^{[6][7]} The first company to offer life insurance in modern times was the Amicable Society for a Perpetual Assurance Office, founded in London in 1706 by William Talbot and Sir Thomas Allen.^{[8][9]} Each member made an annual payment per share on one to three shares with consideration to age of the members being twelve to fifty-five. At the end of the year a portion of the "amicable contribution" was divided among the wives and children of deceased members, in proportion to the number of shares the heirs owned. The Amicable Society started with 2000 members.^{[10][11]}

The first life table was written by Edmund Halley in 1693, but it was only in the 1750s that the necessary mathematical and statistical tools were in place for the development of modern life insurance. James Dodson, a mathematician and actuary, tried to establish a new company aimed at correctly offsetting the risks of long-term life assurance policies, after being refused admission to the Amicable Life Assurance Society because of his advanced age. He was unsuccessful in his attempts at procuring a charter from the government.

His disciple, Edward Rowe Mores, was able to establish the Society for Equitable Assurances on Lives and Survivorship in 1762. It was the world's first mutual insurer and it pioneered age based premiums based on mortality rate laying "the framework for scientific insurance practice and development"^[12] and "the basis of modern life assurance upon which all life assurance schemes were subsequently based".^[13]

Mores also gave the name actuary to the chief official—the earliest known reference to the position as a business concern. The first modern actuary was William Morgan, who served from 1775 to 1830. In 1776 the Society carried out the first actuarial valuation of liabilities and subsequently distributed the first reversionary bonus (1781) and interim bonus (1809) among its members.^[12] It also used regular valuations to balance competing interests.^[12] The Society sought to treat its members equitably and the Directors tried to ensure that policyholders received a fair return on their investments. Premiums were regulated according to age, and anybody could be admitted regardless of their state of health and other circumstances.^[14]



Life insurance premiums written in 2005

The sale of life insurance in the U.S. began in the 1760s. The Presbyterian Synods in Philadelphia and New York City created the Corporation for Relief of Poor and Distressed Widows and Children of Presbyterian Ministers in 1759; Episcopalian priests organized a similar fund in 1769. Between 1787 and 1837 more than two dozen life insurance companies were started, but fewer than half a dozen survived. In the 1870s, military officers banded together to found both the Army (AAFMAA) and the Navy Mutual Aid Association (Navy Mutual), inspired by the plight of widows and orphans left stranded in the West after the Battle of the Little Big Horn, and of the families of U.S. sailors who died at sea.

From the viewpoint of business administration, service quality is an achievement in customer service.^[5] It reflects at each service encounter. Customers form service expectations from past experiences, word of mouth and marketing communications.^[6] In general, customers compare perceived service with expected service, and if the former falls short of the latter the customers are disappointed.

For example, in the case of Taj Hotels Resorts and Palaces, wherein TAJ remaining the old world, luxury brand in the five-star category, the umbrella branding was diluting the image of the TAJ brand because although the different hotels such as Vivanta by Taj- the four star category, Gateway in the three star category and Ginger the two star economy brand, were positioned and categorised differently, customers still expected high quality of Taj.

The measurement of subjective aspects of customer service depends on the conformity of the expected benefit with the perceived result. This in turns depends upon the customer's expectation in terms of service, they might receive and the service provider's ability and talent to present this expected service. Successful companies add benefits to their offering that not only satisfy the customers but also surprise and delight them. Delighting customers is a matter of exceeding their expectations.

Pre-defined objective criteria may be unattainable in practice, in which case, the best possible achievable result becomes the ideal. The objective ideal may still be poor, in subjective terms.

Service quality can be related to service potential (for example, worker's qualifications); service process (for example, the quickness of service) and service result (customer satisfaction).

Individual service quality states the service quality of employees as distinct from the quality that the customers perceived^[7]

II.DISCUSSION

Historically, scholars have treated service quality as very difficult to define and measure, due to the inherent intangible nature of services, which are often experienced subjectively.^[8]

One of the earliest attempts to grapple with the service quality concept came from the so-called Nordic School. In this approach, service quality was seen as having two basic dimensions:^[9]

Technical quality: What the customer receives as a result of interactions with the service firm (e.g. a meal in a restaurant, a bed in a hotel)

Functional quality: How the customer receives the service; the expressive nature of the service delivery (e.g. courtesy, attentiveness, promptness)

The technical quality is relatively objective and therefore easy to measure. However, difficulties arise when trying to evaluate functional quality.^[10]

A customer's expectation of a particular service is determined by factors such as recommendations, personal needs and past experiences. The expected service and the perceived service sometimes may not be equal, thus leaving a gap. The service quality model or the 'GAP model' developed in 1985, highlights the main requirements for delivering high service quality. It identifies five 'gaps' that cause unsuccessful delivery. Customers generally have a tendency to compare the service they 'experience' with the service they 'expect'. If the experience does not match the expectation, there arises a gap.^[11] Given the emphasis on expectations, this approach to measuring service quality is known as the expectancy-disconfirmation paradigm and is the dominant model in the consumer behaviour and marketing literature.^[12]

A model of service quality, based on the expectancy-disconfirmation paradigm, and developed by A. Parasuraman, Valarie A. Zeithaml and Len Berry, identifies the principal dimensions (or components) of service quality and proposes a scale for measuring service quality, known as SERVQUAL. The model's developers originally identified ten dimensions of service quality that influence customer's perceptions of service quality.^[13] However, after extensive testing and retesting, some of the dimensions were found to be autocorrelated and the total number of dimensions was reduced to five, namely - reliability, assurance, tangibles, empathy and responsiveness. These five dimensions are thought to represent the dimensions of service quality across a range of industries and settings.^[14] Among students of marketing, the mnemonic, RATER, an acronym formed from the first letter of each of the five dimensions, is often used as an aid to recall.

In spite of the dominance of the expectancy-disconfirmation paradigm, scholars have questioned its validity. In particular scholars have pointed out the expectancy-disconfirmation approach had its roots in consumer research and was fundamentally concerned with measuring customer satisfaction rather than service quality. In other words, questions surround the face validity of the model and whether service quality can be conceptualised as a gap.^[15]

Measuring service quality may involve both subjective and objective processes. In both cases, it is often some aspect of customer satisfaction which is being assessed. However, customer satisfaction is an indirect measure of service quality. Research has also indicated that the presence of service quality leads to several outcomes including changes in perceived value, customer satisfaction and loyalty intentions with consumers^{[16][17]}

The person responsible for making payments for a policy is the policy owner, while the insured is the person whose death will trigger payment of the death benefit. The owner and insured may or may not be the same person. For example, if Joe buys a policy on his own life, he is both the owner and the insured. But if Jane, his wife, buys a policy on Joe's life, she is the owner and he is the insured. The policy owner is the guarantor and they will be the person to pay for the policy. The insured is a participant in the contract, but not necessarily a party to it.

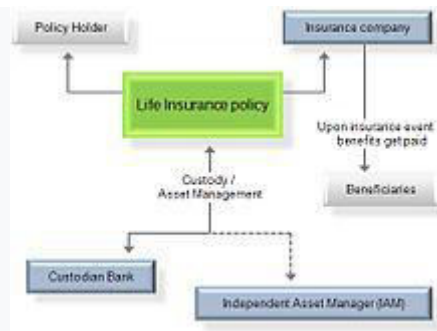


Chart of life insurance

The beneficiary receives policy proceeds upon the insured person's death. The owner designates the beneficiary, but the beneficiary is not a party to the policy. The owner can change the beneficiary unless the policy has an irrevocable beneficiary designation. If a policy has an irrevocable beneficiary, any beneficiary changes, policy assignments, or cash value borrowing would require the agreement of the original beneficiary.

In cases where the policy owner is not the insured (also referred to as the *celui qui vit* or CQV), insurance companies have sought to limit policy purchases to those with an insurable interest in the CQV. For life insurance policies, close family members and business partners will usually be found to have an insurable interest. The insurable interest requirement usually demonstrates that the purchaser will actually suffer some kind of loss if the CQV dies. Such a requirement prevents people from benefiting from the purchase of purely speculative policies on people they expect to die. With no insurable interest requirement, the risk that a purchaser would murder the CQV for insurance proceeds would be great. In at least one case, an insurance company that sold a policy to a purchaser with no insurable interest (who later murdered the CQV for the proceeds), was found liable in court for contributing to the wrongful death of the victim (*Liberty National Life v. Weldon*, 267 Ala.171 (1957)).

III.RESULTS

The insurance company calculates the policy prices (premiums) at a level sufficient to fund claims, cover administrative costs, and provide a profit. The cost of insurance is determined using mortality tables calculated by actuaries. Mortality tables are statistically based tables showing expected annual mortality rates of people at different ages. As people are more likely to die as they get older, the mortality tables enable insurance companies to calculate the risk and increase premiums with age accordingly. Such estimates can be important in taxation regulation.^{[15][16]}

In the 1980s and 1990s, the SOA 1975-80 Basic Select & Ultimate tables were the typical reference points, while the 2001 VBT and 2001 CSO tables were published more recently. As well as the basic parameters of age and gender, the newer tables include separate mortality tables for smokers and non-smokers, and the CSO tables include separate tables for preferred classes.^[17]

The mortality tables provide a baseline for the cost of insurance, but the health and family history of the individual applicant is also taken into account (except in the case of Group policies). This investigation and resulting evaluation is termed underwriting. Health and lifestyle questions are asked, with certain responses possibly meriting further investigation.

Specific factors that may be considered by underwriters include:

- Personal medical history;^[18]
- Family medical history;^[19]
- Driving record;^[20]
- Height and weight matrix, otherwise known as BMI (Body Mass Index).^[21]

Based on the above and additional factors, applicants will be placed into one of several classes of health ratings which will determine the premium paid in exchange for insurance at that particular carrier.^[20]

Life insurance companies in the United States support the Medical Information Bureau (MIB),^[22] which is a clearing house of information on persons who have applied for life insurance with participating companies in the last seven years. As part of the application, the insurer often requires the applicant's permission to obtain information from their physicians.^[23]



Automated Life Underwriting is a technology solution which is designed to perform all or some of the screening functions traditionally completed by underwriters, and thus seeks to reduce the work effort, time and data necessary to underwrite a life insurance application.^[24] These systems allow point of sale distribution and can shorten the time frame for issuance from weeks or even months to hours or minutes, depending on the amount of insurance being purchased.^[25]

The mortality of underwritten persons rises much more quickly than the general population. At the end of 10 years, the mortality of that 25-year-old, non-smoking male is 0.66/1000/year. Consequently, in a group of one thousand 25-year-old males with a \$100,000 policy, all of average health, a life insurance company would have to collect approximately \$50 a year from each participant to cover the relatively few expected claims. (0.35 to 0.66 expected deaths in each year × \$100,000 payout per death = \$35 per policy.) Other costs, such as administrative and sales expenses, also need to be considered when setting the premiums. A 10-year policy for a 25-year-old non-smoking male with preferred medical history may get offers as low as \$90 per year for a \$100,000 policy in the competitive US life insurance market.

Most of the revenue received by insurance companies consists of premiums, but revenue from investing the premiums forms an important source of profit for most life insurance companies. Group insurance policies are an exception to this.

In the United States, life insurance companies are never legally required to provide coverage to everyone, with the exception of Civil Rights Act compliance requirements. Insurance companies alone determine insurability, and some people are deemed uninsurable. The policy can be declined or rated (increasing the premium amount to compensate for the higher risk), and the amount of the premium will be proportional to the face value of the policy.

Many companies separate applicants into four general categories. These categories are preferred best, preferred, standard, and tobacco. Preferred best is reserved only for the healthiest individuals in the general population. This may mean, that the proposed insured has no adverse medical history, is not under medication, and has no family history of early-onset cancer, diabetes, or other conditions. Preferred means that the proposed insured is currently under medication and has a family history of particular illnesses. Most people are in the standard category.

People in the tobacco category typically have to pay higher premiums due to higher mortality. Recent US mortality tables predict that roughly 0.35 in 1,000 non-smoking males aged 25 will die during the first year of a policy.^[26] Mortality approximately doubles for every additional ten years of age, so the mortality rate in the first year for non-smoking men is about 2.5 in 1,000 people at age 65.^[26] Compare this with the US population male mortality rates of 1.3 per 1,000 at age 25 and 19.3 at age 65 (without regard to health or smoking)^[27]

IV.CONCLUSIONS

According to section 80C of the Income Tax Act, 1961 (of the Indian penal code) premiums paid towards a valid life insurance policy can be exempted from the taxable income. Along with life insurance premiums, section 80C allows an exemption for other financial instruments such as Employee Provident Fund (EPF), Public Provident Fund (PPF), Equity Linked Savings Scheme (ELSS), National Savings Certificate (NSC), and health insurance premiums are some of them. The total amount that can be exempted from the taxable income for section 80C is capped at a maximum of INR 150,000.^[30] The exemptions are eligible for individuals (Indian citizens) or Hindu Undivided Family (HUF).

Apart from tax benefit under section 80C, in India, a policy holder is entitled for a tax exemption on the death benefit received.^[31] The received amount is fully exempt from Income Tax under Section 10(10D).

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